



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 SOUTH MCCOLL RD
EDINBURG TX 78539-9152

Respondent Name

OLD REPUBLIC GENERAL INSURANCE

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-11-2376-01

MFDR Date Received

March 8, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Chapter 134.403 TAC/Contract"

Amount in Dispute: \$512.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier will file a supplement response with TDI once the additional review of the bill has been completed."

Response Submitted by: Gallagher Basset Services, Inc., 6504 International Pkwy, Plano, Texas 75093

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2010	Outpatient Hospital Services	\$512.28	\$490.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
 - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
 - 96 – NON-COVERED CHARGE(S).
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CO
 - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – “CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The submitted documentation does not include a complete copy of the alleged contract that the respondent seeks to apply. No documentation was found to support that the insurance carrier is a party to the alleged contract. No documentation was found to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the time period that the disputed services were rendered. No documentation was found to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time the disputed services were rendered. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$12.12. 125% of this amount is \$15.15
 - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility

payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.14. 125% of this amount is \$13.93

- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$5.62. 125% of this amount is \$7.02
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.60. 125% of this amount is \$10.75
- Procedure code 86885 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of \$7.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$4.70. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$4.18. The non-labor related portion is 40% of the APC rate or \$3.13. The sum of the labor and non-labor related amounts is \$7.31. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$7.31. This amount multiplied by 200% yields a MAR of \$14.62.
- Procedure code 86900 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of \$7.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$4.70. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$4.18. The non-labor related portion is 40% of the APC rate or \$3.13. The sum of the labor and non-labor related amounts is \$7.31. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$7.31. This amount multiplied by 200% yields a MAR of \$14.62.
- Procedure code 86901 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0409, which, per OPPS Addendum A, has a payment rate of \$7.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$4.70. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$4.18. The non-labor related portion is 40% of the APC rate or \$3.13. The sum of the labor and non-labor related amounts is \$7.31. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$7.31. This amount multiplied by 200% yields a MAR of \$14.62.
- Procedure code 73550 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$23.93. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$41.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$41.89. This amount multiplied by 200% yields a MAR of \$83.78.
- Procedure code 12001 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0133, which, per OPPS Addendum A, has a payment rate of \$91.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$54.77. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$48.65. The non-labor related portion is 40% of the APC rate or \$36.51. The sum of the labor and non-labor related amounts is \$85.16. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$85.16. This amount multiplied by 200% yields a MAR of \$170.32.

- Per Medicare policy, procedure code 99284 may not be reported with procedure code 94761 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$223.17. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.90. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$118.94. The non-labor related portion is 40% of the APC rate or \$89.27. The sum of the labor and non-labor related amounts is \$208.21. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$208.21. This amount multiplied by 200% yields a MAR of \$416.42.
 - Procedure code 94761 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90718 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J0696 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.40. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$13.68. The non-labor related portion is 40% of the APC rate or \$10.27. The sum of the labor and non-labor related amounts is \$23.95. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$23.95. This amount multiplied by 200% yields a MAR of \$47.90.
 - Per Medicare policy, procedure code 96374 may not be reported with procedure code 12001 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96374 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$37.44. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.46. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$19.95. The non-labor related portion is 40% of the APC rate or \$14.98. The sum of the labor and non-labor related amounts is \$34.93. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$34.93. This amount multiplied by 200% yields a MAR of \$69.86.
4. The total allowable reimbursement for the services in dispute is \$878.99. This amount less the amount previously paid by the insurance carrier of \$388.86 leaves an amount due to the requestor of \$490.13. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$490.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$490.13, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/>	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Grayson Richardson Medical Fee Dispute Resolution Officer	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> November 1, 2013 Date
Signature		

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.